STATE OF CALIFORNIA- HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
1700 K STREET
SACRAMENTO, CA 95814-4037
TDD (916) 445-1942
(916) 323-0450

TO: _____, Drug Medi-Cal Services

SUBJECT: REJECTED TAPE/DISK

DATE: _____

Enclosed are the following tape/diskette(s) submitted for Drug Medi-Cal Reimbursement:

Claim Month/Year	**Batch Number**	**Program Code**	**Total Dollars**

Refer to the enclosed report for an explanation of why the tape or disk could not be processed. Please correct and return the rejected tape/diskette(s) within two weeks of the date of this letter.

If you have any questions, please call me at _____. Thank you.

Sincerely,

_____
Drug Medi-Cal Claims Analyst
Fiscal Management Branch
Program Operations Division

Enclosure(s)

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RETURN SLIP FOR REJECTED DISKS AND TAPES
(Detach and send with corrected disk or tape)

County or Direct Provider Name_____

County Code or Direct Provider Number_____ Program Code _____
Batch Number_____ Claim Month/Year _____

Total Dollar Amount _____ Total Records_____

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